Ireland: national report for 2015 - Prison

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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(2016) *Ireland: national report for 2015 – drugs*

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European Monitoring Centre for Drugs and Drug Addiction

Table of Contents

0. Summary

0.1 National profile

There are 14 institutions in the Irish prison system comprising 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy prison in Dublin and the remainder are located in a separate part of Limerick prison.

Political responsibility for the prison system in Ireland is vested in the Minister for Justice, Equality and Defence. The Irish Prison Service (IPS) operates as an executive agency within the Department of Justice, Equality and Defence. It is headed by a Director General supported by seven directors. The Office of the Inspector of Prisons is a statutory, independent office established to carry out regular inspections of the 14 prisons and to report to the Minister for Justice, Equality and Defence. Four policy documents have a particular bearing on the provision of drug-related healthcare in the Irish prison system – the IPS policy and strategy document, Keeping drugs out of prisons, and the National Drugs Strategy (interim) 2009–2016, the IPS three-year strategic plan 2012–2015, and the joint IPS–Probation Service strategic plan 2015–2017.

One of the key benchmark criteria relevant to the treatment of prisoners is equivalence of care. This, according to the Inspector of Prisons, is the minimum legal standard required in prison healthcare and entitles prisoners to the same care as that available in the community. Since the launch of the Irish Prison Service (IPS) drugs policy and strategy document, Keeping drugs out of prisons, the provision of drug services in Irish prisons has improved. The contracting-out of treatment services to addiction services based in the community and to private consultants including pharmacists has also been beneficial and has enhanced links between prison and community-based services. The IPS and the Probation Service have a multi-agency approach to offender and rehabilitation from pre- and post-imprisonment in order to reduce offending and improve prisoner outcomes. The availability of drugs within prisons is a cause of concern and prison visiting committees have described the situation as extremely worrying. It impedes the work of providing support and counselling in prisons.

0.2 New developments

Although there has been an improvement in drug-related health policies and services in Irish prisons in recent years, the effective delivery of these services and the attainment of the goal of equivalence of care have been has been hampered because of overcrowding. In such a context the therapeutic benefit of drug treatment can become a secondary concern to the control and security priorities of the prison environment. Equally, a lack of clarity of responsibility and coherence of delivery hinders the provision of a seamless care service pre and post release and exposes vulnerable people to preventable drug-related deaths. A number of initiatives have recently been introduced by the IPS in collaboration with the Probation Service which are helping, or have the potential to help, address these issues.

1. National profile

1.1 Organization

There are 14 institutions in the Irish prison system comprising 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy Prison in Dublin and the remainder are located in a separate part of Limerick prison.

Table 1.1.1. Irish prison population, 2014

Prison name	Description	Operational capacity	Population (average 2014)
Mountjoy Prison	Closed, medium-security prison for males aged 18 years and over. It is the main committal prison for Dublin city	554	556
Dóchas Centre	Closed, medium-security prison for females aged 18 years and over. It is the committal	105	123

	prison for females committed on remand or sentenced from all courts outside the Munster area		
Training Unit, Mountjoy	A semi-open, low-security prison for males aged 18 years and over, with a strong emphasis on work and training	96	89
Arbour Hill Prison	A closed, medium-security prison for males aged 18 years and over.	142	141
Castlerea Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for remand and sentenced prisoners in the west of Ireland.	340	338
Cork Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for the south west of Ireland	210	226
Limerick Prison	Closed, medium-security prison for males and females aged 18 years and over. It is the committal prison for the mid-west of Ireland	220 (m) 28 (f)	223 (m) 27 (f)
Loughan House	Open, low-security prison for males aged 18 years and over.	140	119
Shelton Abbey	Open, low-security prison for males aged 19 years and over.	115	102
Portlaoise Prison	A closed, high-security prison for males aged 18 years and over. It is the committal prison for those sent from the Special Criminal Court	291	246
Midlands Prison	Closed, medium-security prison for males aged 18 years and over. It is the committal prison for the Irish midlands	870	823

Source: IPS website 2015

1.2 Drug use and related problems among prisoners

1.2.1 Drug use prior to imprisonment and inside prison

In 2010 the National Advisory Committee on Drugs (NACD) commissioned a study to:

- describe the nature, extent and pattern of consumption for different drugs among the prisoner population;
- describe methods of drug use, including intravenous drug use, among the prisoner population;
- estimate the prevalence of blood-borne viruses among the prisoner population and identify associated risk behaviours; and
- measure the uptake of individual drug treatment and harm reduction interventions (including hepatitis B vaccination) in prison.

The NACDA published this study in 2014 ((Drummond*, et al.* 2014)) and a summary was included in the 2014 National Report (Section 4.3.2).

1.2.2 - Drug related problems, risk behaviour and health consequences

Much of the information available relating to drug use in Irish prisons and responses is obtained through answers to parliamentary questions (PQs) put to the Minister for Justice and Equality in Ireland's national assembly, Dáil Éireann.

In response to a PQ on 24 September 2014, Minister Frances Fitzgerald said that, of the 3,792 prisoners in custody across the Irish prison system on 31 August 2014, 530 or almost 14% were serving sentences for drug-related offences. In 2013 there were 846 committals to prison under sentence for controlled drug offences. This represented a decrease of 8% on the 2012 figure of 922 (Fitzgerald F 2014, 24 September) See Section 1.2.1 in *national report for 2015 – drug markets and crime* for further details of drug law offences.

On the issue of searches for drugs in prison Minister Fitzgerald, in response to a PQ on 19 May 2015, said she had been informed by the Irish Prison Service (IPS) that there had been 117 searches for drugs in Mountjoy Prison, the largest prison in the country, between 1 February 2015 and 14 May 2015 and that 42 seizures of drugs had resulted from the these searches. She explained that the IPS was examining a number of measures to deal with the major challenge posed

by the availability of drugs in prison. These measures included the expansion of the canine unit, the introduction of a confidential telephone line to identify sources of drug trafficking into prisons, and measures to improve addiction treatment in prisons (Fitzgerald F 2015a).

A PQ asking for clarification on Government policy with regard to supporting prisoners' accommodation needs following release provided some detail on inter-agency measures to ensure such people did not become homeless or exposed to an active drug scene in emergency accommodation (Fitzgerald F 2015b). Minister Fitzgerald informed the House that, as a direct result of contact with the IPS, the Minister responsible for the National Action Plan on Homelessness (Department of Environment Community and Local Government 2014) had included an action which stated 'staff from the Department of Social Protection will work with housing authorities and the Irish Prison Service to provide an appropriate in-reach service to all prison settings to ensure that prisoners are assisted to find accommodation before release'.

See Section 3.1 below for an account of the introduction of drug-free units into Irish prisons since 2012.

Prison visiting committees reports
A visiting committee is appointed to each prison under the Prisons (Visiting Committees) Act 1925 and the Prisons (Visiting Committees) Order 1925. Members of the 14 visiting committees are appointed by the Minister for Justice, Equality and Defence for a term not exceeding three years. The function of prison visiting committees is to visit at frequent intervals the prison to which they are appointed and hear any complaints which may be made to them by any prisoner. They report to the Minister any abuses observed or found by them in the prison and any repairs which they think are urgently needed. Visiting committee members have free access either collectively or individually to every part of the prison to which their Committee is appointed.

The 2014 Annual Report of the visiting committee for Mountjoy Prison reported that 'considerable amounts of drugs are being made available to prisoners' (Prison visiting committees 2015) (p.4). The committee recommended that a high priority be given to addressing externally the flow of drugs into the prison in the coming year. The report of the Limerick Prison visiting committee also highlighted problems associated with drug availability and the negative impact this was having on treatment and rehabilitation activities: 'Substance abuse and availability of illicit drugs within the prison despite the best efforts of the Governor and his staff is extremely worrying and undermines the efforts of all those involved in providing support and counselling services' (Prison visiting committees 2015) (p.6).

1.3 Drug-related health responses in prisons

1.3.1 Drug-related prison health policy
Four policy documents are shaping the provision of drug-related healthcare in the Irish prison system.

Keeping drugs out of prisons
In May 2006 the Minister for Justice launched *Keeping drugs out of prisons: drug policy and strategy* (Irish Prison Service 2006). This set out the steps required to tackle the supply of drugs into prisons, to provide adequate treatment services to those addicted to drugs, and to ensure that developments in the prisons were linked to those in the community. The IPS, in partnership with statutory and voluntary agencies, provides programmes to assist in the areas of prevention, treatment, rehabilitation and aftercare, both to address the harmful effects of substance use and to prevent the spread of HIV, hepatitis B and C and other infections. Phase 1 of this policy involved putting in place the necessary staffing levels to provide the required services to prisoners, and Phase 2 sought to provide prisoners with access to a range of drug treatment options.

National drugs strategy (*interim*) 2009–2016
The following actions in the NDS relate to treatment in prisons (Department of Community 2009):

- Treatment and rehabilitation (Action 43) – continue the expansion of treatment, rehabilitation and other health and social services in prisons and develop an agreed protocol for the

seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community; and

- Research/information (Action 55) – research prevalence patterns of problem substance use among prisoners.

The Steering Group that drafted the NDS noted, with regard to the risk of overdose or relapse immediately following release from custody, that there was a need for 'an effective and co-ordinated interagency approach to ensure the seamless transition from prison back into the community. This requires the availability of, and timely access to, a range of supports including suitable accommodation, treatment/counselling services, training/ education/ employment options and personal supports' (para. 4.49). In 2005, the mid-term review of the previous National Drugs Strategy 2001–2008 had recommended that rehabilitation be adopted as a fifth pillar of the strategy (Department of Community 2005). Arising from this recommendation, the HSE appointed an expert working group in 2006 to describe residential treatment services for problem drug and alcohol users in Ireland, to calculate their capacity and to estimate future requirements (O'Gorman and Corrigan 2008). In relation to the issue of throughcare upon release from prison, this expert working group recommended the 'provision of step-down or halfway-house accommodation for newly released prisoners who have been detoxified or who have started rehabilitation programmes…not least because of the vulnerability of such individuals to relapse and overdose' (p. 5).

IPS three-year strategic plan 2012–2015

The 3-year strategic plan committed the IPS to ensuring an increase in the number of prisoners receiving prison-based treatment and programmes designed to aid rehabilitation and reintegration (Irish Prison Service 2012).The IPS also planned to review the IPS's clinical drug policy so as to bring policy into line with changes in community practice (see Section T1.4.1 below for an update). The introduction of drug-free units in all closed prisons and the provision of 'equivalence healthcare to all prisoners in custody' were two actions within the plan (see Section 3.1 below for an update on the creation of drug-free units).

Joint Irish Prison Service and Probation Service strategic plan 2015–2017

The strategy sets out the multi-agency approach offender management and rehabilitation from pre- to post-imprisonment that the IPS and Probation Service will pursue in order to reduce re-offending and improve prisoner outcomes: 'For the majority of those incarcerated, and for those sentenced to sanctions in the community, similar criminogenic needs and risks exist. Lack of employment, abuse of alcohol and drugs, anti-social attitudes and companions, emotional and personal difficulties, poor educational achievement, family problems, and lack of housing or accommodation are prominent among them. Such multiple needs are often interrelated and mutually reinforcing' (Irish Prison Service and Probation Service 2015) (p. 1).

Under Strategic Action 1 – 'We will ensure that all sentenced prisoners can be assisted in their rehabilitation and community reintegration throughout their sentence' – the two services commit to establishing a joint review of funded addiction services to the prisons and in the community, and to examining the potential for a prison-based drug therapeutic community to facilitate better outcomes for prisoners post release.

Under Strategic Action 2 – 'Building on the success of the Community Return Programme of earned early release' – the two services commit to implementing the recommendations of the Programme evaluation (see Section T3.1 below for a brief account of the evaluation), including delivering on an integrated approach by developing rehabilitative initiatives that include work training, education and addiction recovery.

1.3.2 Structure of drug-related prison health responses

Culture and organisation in the Irish prison service: a road map for the future, a new report completed by the Inspector of Prisons, Judge Michael Reilly, and Professor Andrew Coyle, Emeritus Professor of Prison Studies at the University of London, examines all aspects of the administration and governance of the Irish prison system and identifies a number of deficiencies in administration, treatment of prisoners and delivery of services by prison staff (Reilly 2015). The authors are particularly critical of inadequate and misleading reporting, a direct result of the absence of functioning line management structures in many prisons and a factor contributing to consistent

breaches of agreed procedures. The review examines several aspects of the work the 3,380 staff in the Irish Prison Service (IPS), most of whom are prison officers, and recommends significant changes to management structures, career progression and staff reporting. It recommends substantial changes to the prison system's governance structures, in particular with regard to the manner in which the IPS reports to the Government, the appointment of IPS board members and regional management structures.

Recommended reforms include appointing a Director of Prison Healthcare Services, the person appointed to be a registered medical practitioner. The report notes that many prisoners have a poor health profile and providing adequate medical and nursing care in prisons presents significant challenges. The work of healthcare staff within the prisons system will be key to progress in this area: while there has been a steady increase in specialist civilian staff replacing prison officers in recent years, Irish prisons have been much slower than those in the United Kingdom in this regard. Nursing managers in the larger prisons lead teams of qualified nurses and there are 111 nurses currently working in the prison service, with 27 nursing places unfilled.

In contrast to countries like Norway and Scotland, which adhere to international standards relating to the provision of healthcare services in prisons, medical services in Irish prisons are not integrated with the general health administration in the community and prison health policy is not necessarily compatible with national health policy. The authors cite a 2009 Health Service Executive (HSE) report which recognised that the HSE was peripheral to prison healthcare delivery. Recommendations on providing a clear definition of the role of prison nurses have not been implemented and staffing shortages and changes in conditions of employment have contributed to the frustration of nurses, unable to provide the level of nursing care they would wish.

The report observes that progress from a command structure to a management structure inthe prison service lagged far behind that in other areas of public administration. Promotions have traditionally been through the ranks and there has been a blurring of the distinction between staff and management. Many officers spoke of an inflexible culture with an emphasis on ensuring things didn't go wrong, not on introducing new thinking. Promotion to a higher grade generally operates on a generic basis. This means that it has been possible for someone who has spent all of their career to date in a specialism, with minimal direct contact with prisoners or little management of staff, to be promoted to assistant governor or to one of the grades of chief officer and then be appointed to a position that requires first line management of both staff and prisoners. A number of recently appointed assistant chief officers reported that they felt unprepared for their new responsibilities and that they found it difficult to gain appropriate respect from some other officers and even from prisoners. The chapter on staff learning and development highlights the disparity between employment practices in the prison system and the wider public service. It appears that PMDS forms are not filled and after their initial training staff learning and development is not monitored.

The focus of this review was on how the current culture of the Irish prison system contributes to or undermines the development of the prison service. Its terms of reference meant that the authors concentrated on organisational issues, the nature of prison work and the experiences and capacity of staff within the IPS. The prisoners themselves are the subject of just one chapter. It is clear that much progress has been made in recent years in improving the conditions in which prisoners live and in identifying and responding to areas of particular concern. The introduction of a new complaints procedure and thorough investigations of deaths are two recent advances in this regard.

Historically, the autonomy granted to individual Irish prisons has meant that, unlike other countries, where a prisoner's destination is determined largely by an initial classification, prisoners in Ireland are usually allocated to the prison of first committal. The lack of a thorough individual assessment of prisoners militates against attempts to establish internal good order and, in some prisons, contributes the development of gang culture. Gang structures in prisons often mirror external affiliations and can be built around the distribution of drugs, threatening stability in the prison. There does not appear to be a clear operational strategy for dealing with gangs and individual staff members are unable to cope with the violence and intimidation that is part of gang activity. Often it is the victim, not the perpetrator, of this activity who is transferred to another prison or what is called a protective regime.

Several issues relating to management of prisoners and their rehabilitation were beyond the scope of this review. The authors recommend that a separate review should deal comprehensively deal with these and should include the following in its terms of reference:

- health care including mental health, and
- drug and other substance abuse.

1.3.3 Types of drug-related health responses available in prisons

Primary care is the model of care through which healthcare is provided in the prison system. A number of contracted private services assist the Irish Prison Service (IPS) and Health Service Executive (HSE) in the provision of drug treatment services. The service is delivered by a mix of part-time and full-time doctors and nursing staff. Nurses first began working in the IPS in 1999 (Nursing and Midwifery Planning and Development Unit & Irish Prison Service 2009). Addiction counselling services have been provided to the IPS by Merchants Quay Ireland (MQI) since 2007. A voluntary organisation providing services to vulnerable people including drug users, the service operates in 13 prisons throughout the country and provides structured assessments, 1–1 counselling, therapeutic group work and multi-disciplinary care and release planning interventions with clearly defined treatment plans and goals. Services offered by MQI include:

- brief interventions,
- motivational interviewing and motivational enhancement therapy,
- 12-step facilitation programme,
- relapse prevention,
- harm reduction approaches, and
- individual care planning and release planning.

Treated problem drug use in prisons from TDI data

Between 2009 and 2014, 4,676 cases received treatment in prison (Table 1.3.3.1). The treatment, mainly counselling, was provided by in-reach voluntary services or the prison medical service. Between 2009 and 2014, 9.4% of all cases treated received treatment in prison. Of those cases treated in prison, 44.7% were new to treatment.

Table 1.3.3.1 Treated problem drug use in prison, NDTRS 2009 to 2014

	2009	2010	2011	2012	2013	2014
Total	793	916	753	636	743	835
New treatment entrants	461	471	337	264	270	285
Previously treated	307	406	393	324	446	505
Treatment status unknown	25	39	23	48	27	45

All treatment entrants in prison

For the period, the main problem drug reported by all treatment entrants was opiates (mainly heroin) (57.8%) (Figure 1.3.3.1). For the period 2009 to 2014, cocaine was the second most common drug reported (15.5%). However in 2014, benzodiazepines (14.9%) overtook cannabis (14.5%) as the second most common problem drug, with cocaine (13.1%) dropping to fourth most common drug reported. Just over a third of cases (34.6%) reported ever injecting.

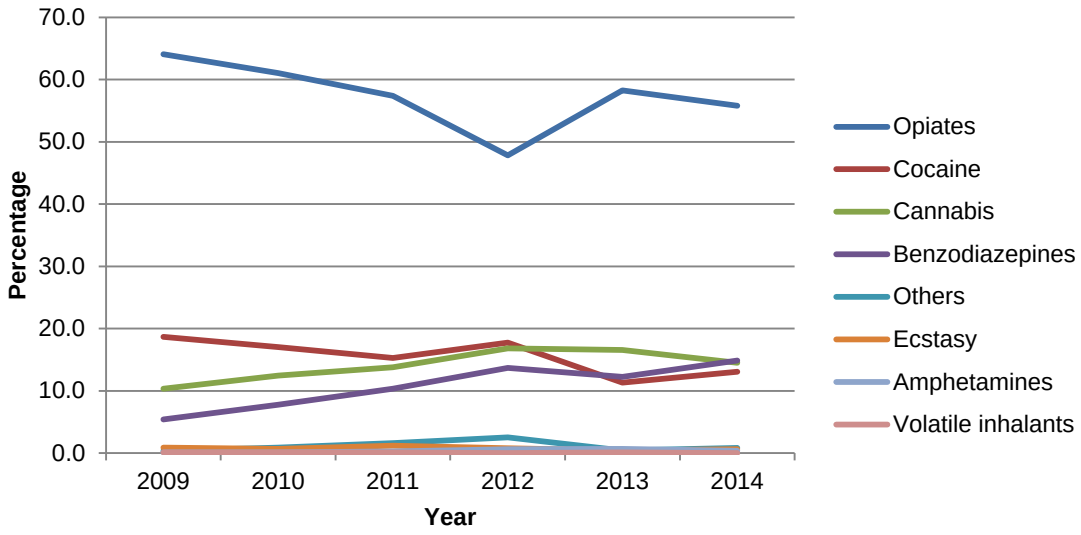

Figure 1.3.3.1. Main problem drug (excluding alcohol), all treatment entrants in prison, by year, NDTRS 2009 to 2014

Almost all cases in treatment were male (96.4%) and the mean age was 29 years. The highest proportion of cases over the period 2009 to 2014 were aged 20 to 24 years (27.2%).

New treatment entrants in prison

For the period, the main problem drug reported by all cases was opiates (mainly heroin) (46.9%) (Figure 1.3.3.2). For the period 2009 to 2014, cocaine was the second most common drug reported (20.4%). However in 2014, benzodiazepines (25.3%) overtook cannabis (20.4%) as the second most common problem drug, with cocaine (19.6%) dropping to fourth most common drug reported. Among this group, 22.8% reported every injecting.

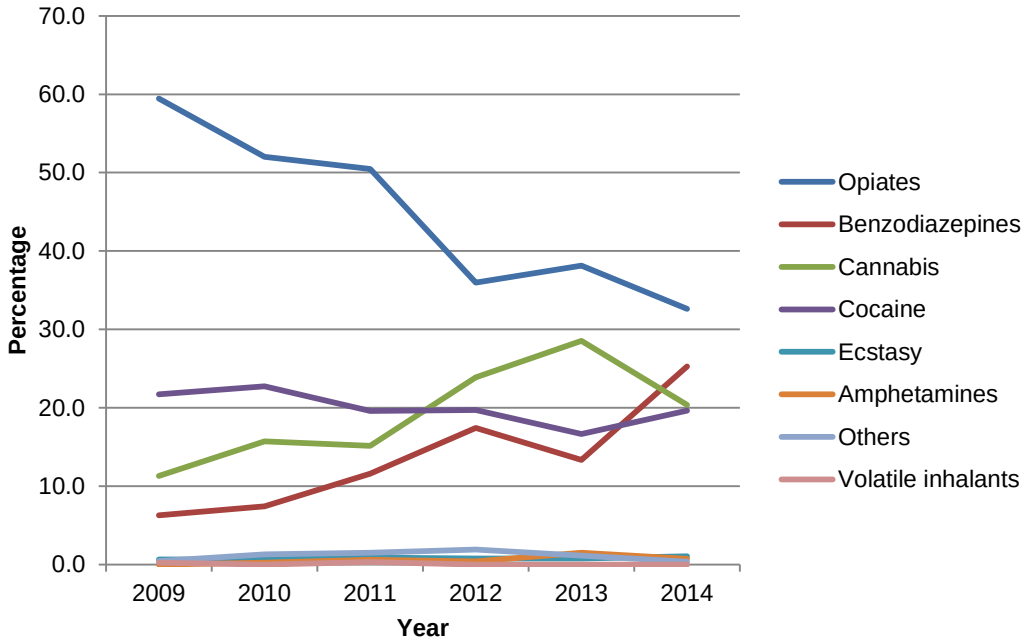

Figure 1.3.3.2 Main problem drug (excluding alcohol), new treatment entrants in prison, by year, NDTRS 2009 to 2014

Almost all new entrants to treatment were male (97.6%) and the mean age was 28 years. The highest proportion of cases over the period 2009 to 2014 were aged 20 to 24 years (30.8%).

MQI, in partnership with Ana Liffey Drug Project, Ballymun Youth Action Project and Coolmine Therapeutic Community, deliver a structured multi-agency 8-week drug treatment programme (DTP) in the Mountjoy Medical Unit. The programme helps prisoners to detox from methadone and benzodiazepines (Merchants Quay Ireland 2014).

There were 3,065 prisoners referred to the MQI addiction services during 2013, a 10% increase since 2011. During 2013 there were 11,452 counselling sessions delivered to prisoners by the MQI Addiction Counselling service, an 11% increase on 2011.
The dispensing of methadone by drug treatment pharmacists in Mountjoy Prison is described in Section 5.2.2.2 of the 2014 National Report.

Patients on methadone programmes, Wheatfield prison
Methadone maintenance treatment (MMT) became available through the Irish Prison Service (IPS) in 2002. Wheatfield Prison is a closed, medium-secure prison for men, with an official capacity of 700. On 3 October 2011, of the 664 prisoners in the prison, 119 (18%) were receiving MMT. A descriptive study of all 119 prisoners on MMT on that date, from the electronic medical records, was published in 2014 (Galander*, et al.* 2014). The main characteristics are summarised below.

- Mean age was 33 years (range 21 to 58 years).
- 78% were classified as either medium or full security risk.
- Mean sentence length was four years (range 1 month to 15 years); 2% were on remand; 44% were serving a sentence of one month to two years; and 34% were serving a sentence of three to six years.
- Mean methadone dose was 55 mg (range 4 mg to 180 mg), and 62% were on 60 mg or less.
- 7% were HIV positive, and 7/8 of those who were HIV positive were on antiretroviral therapy.
- 38% were hepatitis C positive, and none were on hepatitis C treatment at the time of the study.
- 1% were hepatitis B positive; 7% were recorded as having a hepatitis B vaccination.
- 2% were being treated for active tuberculosis.
- 50% were prescribed other psychotropic medication – 24% anti-depressants, 18% anti-psychotics, 7% hypnotics, and 1% mood stabiliser.
- 16% were attending addiction counselling services.

The profile of the prisoners on MMT in Wheatfield – their drug use prevalence, demographic data, sentencing details, medical and psychiatric history – was similar to the profile of prisoners who have participated in other studies on this topic. Given that 18% of the population of Wheatfield Prison were on MMT on the day of the study, the authors concluded that MMT is now a significant medical undertaking in the IPS. They highlighted several issues in the management of MMT in Irish prisons:

- *Viral screening:* there were gaps in documentation of prisoner status with regard to HIV (33%), hepatitis C (29%), and hepatitis B (73%). Using only information on documented hepatitis C status, the authors found that 54% (45/84) of prisoners on MMT were hepatitis C positive. They highlighted the need for improved viral screening for this high-risk group.
- *Methadone dosages*: the authors explained the wide range in methadone dosages as being probably due to an older population, on extended sentences, who had stabilised their opiate use, often through an agreed, gradually reduced methadone regime. The highest dosages were explained by well recognised pharmacokinetic interactions with TB medication, which necessitated higher dosages.
- *Extended aftercare*: the authors recommended extended aftercare for prisoners who voluntarily worked to reduce their methadone dosage in order reduce the risk of overdose.

Take-home naloxone: The authors highlighted the need for take-home naloxone for prisoners when released, to reduce the risk of fatal overdose and also to fast-track prisoners back into MMT where necessary.

1.4 Quality assurance of drug-related health prison responses

1.4.1 Overview of the main treatment quality assurance standards, guidelines and targets

In 2012 the *Drug treatment clinical policy (Irish Prison Service 2008)* was reviewed to ensure that services provided in prisons were equivalent to those provided in the community. In its annual report for 2012, the Irish Prison Service (IPS) stated:

> The…Clinical Drug Policy was reviewed and amended during the course of 2012 to reflect best practice guidelines and changes in practice in the community. This work involved consultation with prison and wider community providers of drug treatment services (Irish Prison Service 2013)(p. 29).

Further information on this review and on the available drug services in Irish prisons was provided by the then Minister for Justice, Alan Shatter TD, in response to a Parliamentary Question (Shatter 2013, 30 May):

> The policy was examined in detail by a multidisciplinary group, including representatives from community, voluntary and statutory stakeholders, and Irish Prison Service healthcare staff. It was amended to reflect changes in legislation and practice in the community, including the statutory requirements in relation to HIV testing and notification, and the development of In Reach services for the treatment of Hepatitis C. The Drug Treatment Clinical Policy now encompasses the following:
> - Addiction Treatment Charter;
> - Clinical Interdisciplinary Care Planning;
> - Psychosocial Supports and Pharmacological Interventions for Opioid Dependence;
> - Drug Testing;
> - Dispensing and Administration of Methadone;
> - Viral Screening;
> - Immunisation Guidelines;
> - Assessment and Treatment of Benzodiazepine Addiction;
> - Assessment and Treatment of Alcohol Withdrawals;
> - Cocaine Treatment Policy; and
> - Nicotine Replacement Therapy Policy.

In a separate response to a Parliamentary Question about drug detoxification (Shatter 2013, 6 February), the Minister reported that 'recent trends across prisons indicate a significant number of prisoners currently self-detoxing from methadone and a marked reduction in the average dose of methadone'. He elaborated on the implementation of relevant proposals in the 2012 review:

- A therapeutic Detoxification and Rehabilitation Treatment Programme (DRTP) was to be established, with the allocation of 10 additional places from March 2013. The DRTP would also operate in the Medical Unit (Mountjoy Prison) and be in addition to the existing DTP, which had 9 places. Circa 50 beds in the Medical Unit, Mountjoy Prison would be used exclusively for drug treatment programmes including the:
    - Drug Treatment Programme (DTP) – 8 week duration,
    - Detoxification and Rehabilitation Treatment Programme (DRTP) – 6 week duration,
    - Slow Detoxification Programme – maximum duration 6 months, and
    - Stabilisation Programme – maximum duration 6 months.
- The Training Unit and Shelton Abbey were to be designated as suitable for prisoners on MMT. Loughan House was to be designated as a facility for the treatment of prisoners seeking to return to a drug-free lifestyle.

Finally, the Minister stated that progression from these programmes would include access to drug-free units, open prisons and ultimately the Community Return Programme (see Section 2.1 below).

2. New developments

2.1 New or topical developments

Closure of St Patrick's Institution

Following sustained criticism of conditions in St Patrick's young offenders' institution over many years, the Minister for Justice announced in July 2013 that it was due to be closed within six months (Shatter 2013, 3 July). The process of removing prisoners from St Patrick's institution continued throughout 2014.

Drug-free units

Drug-free units (DFUs), in accordance with the Irish Prison Service (IPS) Strategic Plan 2012–2015, were due to be established in all closed prisons (Irish Prison Service 2012). In October 2013 the Jesuit Centre for Faith and Justice (JCFJ) published a report on the progress achieved under the IPS strategic plan (Jesuit Centre for Faith andJustice 2013); ((Health Research Board 2013)

(Chapter 9.8.1). The JCFJ stated that DFUs currently existed in seven closed prisons, with 417 spaces available. Despite a commitment by the IPS to establish DFUs in all prisons by the end of 2013, the JCFJ reported that they were still not available for approximately one quarter of the prison population: 'With no drug-free unit in either prison of the midland complex, which includes Ireland's largest prison, more than 1,000 prisoners do not have access to drug-free accommodation' (p. 19). The report also noted that, according to the Department of Justice, 91% of national drug-free accommodation places were filled. In its Annual Report for 2014, the IPS stated that DFUs were now implemented in all closed prisons (Irish Prison Service 2015).

In response to a recent Parliamentary Question on the issue (Fitzgerald F 2015c), Minister for Justice and Equality Frances Fitzgerald stated that there are currently DFUs operational in seven closed prisons: Mountjoy, Dochas Centre, Cloverhill, Limerick, Cork, Castlerea and Wheatfield. There is, explained the Minister, 'an aggregate total of 560 spaces in these units, which currently house 486 prisoners with 74 spaces available. The majority of Units operate at or close to their capacity and prisoners are only accommodated in such Units when they meet the strict criteria which applies including evidence of drug free status'.

These aggregate figures break down as follows:

- Mountjoy Male Prison: 54 spaces, with 48 prisoners currently in the Unit and 6 spaces;
- Dochas Centre: 55 spaces, with 40 prisoners currently in the Unit, and 15 spaces available;
- Wheatfield Place of Detention: 180 spaces, with 163 prisoners currently in the Unit, and 17 spaces available;
- Cloverhill Prison: 52 spaces, with 33 prisoners currently in the Unit, and 19 spaces;
- Limerick Prison: 45 spaces, with 45 prisoners currently in the Unit and no spaces;
- Cork Prison: 34 spaces, with 30 prisoners currently in the Unit, and 4 spaces; and

Castlerea Prison: 140 spaces, with 127 prisoners currently in the Unit, and 13 spaces.
The absence of a DFU in the Midlands complex, which includes Ireland's largest prison, remains an issue.

Integrated Service Management
Since 2008, newly committed prisoners with a sentence of greater than one year have been eligible to take part in Integrated Sentence Management (ISM). Under ISM, prisoners take greater personal responsibility for their own development through active engagement with both specialist and non-specialist services in the prisons. ISM represents a prisoner-centred, multi-disciplinary approach to working with prisoners, with provision for initial assessment, goal setting and periodic reviews to measure progress.

In total, 6,460 prisoners have been offered participation in ISM since it began as a pilot project in 2008. A total of 24 dedicated ISM Coordinators are now operational in all prisons and open centres. The allocation of dedicated staff in each establishment greatly enhances the effectiveness of the sentence management system and facilitates the growing numbers of prisoners participating in the process. To enhance consistency of delivery across the prison estate a dedicated ISM Coordinator training course was delivered in the IPS College in 2014. ISM Coordinators are also active participants in sentence planning for certain categories of prisoners serving less than one year, for example, female prisoners and prisoners at risk of homelessness on release.

Community Return Programme
The ISM process has been a key factor in the success of the Community Return Scheme.
The Community Return Programme is a joint Probation Service and Irish Prison Service (IPS) initiative, begun as a pilot between October 2011 and April 2012, under which selected prisoners are granted temporary release on condition they perform unpaid supervised work in the community (Health Research Board 2013) (Chapter 9.9). The success of the pilot led to the programme being mainstreamed.

An evaluation was recently conducted to assess the operation, impact, and effectiveness of the Community Return Programme (Irish Prison Service Probation Service 2014). The study cohort comprised all 761 Community Return Programme participants between October 2011 and December 2013. It was found that 40% of participants had been convicted on drug offences. Eighty-

eight, approximately 11%, had breached conditions and were returned to custody, while almost 89% had either successfully completed the programme or were still working on it. Of those participants (n=233) released during the first year of the programme, 91% had not been committed to prison on a new custodial sentence in the period up to the end of 2013.

Participants identified particular benefits of the Programme as being the structure and routine which aided re-integration, the work ethic and self-esteem developed, their positive profile in working in the community and the learning of work skills transferable to employment. According to some participants, the programme helped them stay out of trouble by keeping them occupied, providing positive supports and a starting point to build on, particularly in the early stages after release.

Review of drugs and alcohol services for offenders announced
On 18 May 2015 the Minister for Justice, Defence and Equality, Frances Fitzgerald TD, launched the Joint Probation Service and Irish Prison Service Strategy covering the years 2015 to 2017 (Fitzgerald F 2015d). In launching the strategy, described in Section T1.3.1 above, the Minister stated, 'Tackling drugs in prison and among offenders on probation must be a top priority. Enforcement is one approach which we are pursuing. But improved addiction services for offenders are also vital. With this in mind I have given my approval to the commissioning of a review of drugs and alcohol services to offenders.' The review will examine and set out a pathway for the provision of improved alcohol and addiction services for offenders. The HSE will also take part in the review.

Motivational intervention for problem substance users in prison
An evaluation of a group-based motivational intervention, developed in order to identify and engage with substance users in a prison setting at an earlier stage with regard to their drug use, was recently conducted (Harper and O'Rourke 2015).

The motivational intervention was based on motivational interviewing and the Prochaska and Di Clemente trans-theoretical model of behaviour change. Motivational interviewing is defined as 'a client-centered directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence'. After the intervention the authors expected that participants would show:

- increased recognition of their problem behaviour,
- decreased ambivalence towards their drug use, or
- positive behavioural change in relation to their drug use.

Prisoners in Mountjoy Prison who were current substance users were invited to participate in the intervention programme. Those with active psychiatric illness or a release date before the end of the programme were not included. There were 76 potential participants: 44 were offered a place on the programme and 38 accepted. Each participant gave informed consent. Eleven potential participants were put on a wait list and formed the control group. The 12-session group-based motivational intervention took six weeks and each session lasted 1½ hours.

Demographic data, sentencing details, drug use history, risk behaviour and current engagement with treatment services were collected for each participant using a semi-structured interview. The primary outcome measure of treatment effectiveness was collected using the internationally validated questionnaire – Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). This measures a participant's readiness for change. It was filled out by the participant (self-reported) before and after the treatment. Retention rates in the programme were 88% at two weeks and 76% (n=31) at six weeks. Information on the seven who had dropped out by the sixth week was not included in the final analysis. The mean age of the participants was 31 years and all were male. Most were incarcerated for non-violent drug crimes (39%), followed by violent crime (35%). Opiates were the main drug used (71%). Three quarters (74%) reported ever injecting while nearly half (48%) reported recent injecting drug use. No statistically significant difference was found between the characteristics of the participants and the control group.

Reported limitations of the study included small sample size, lack of randomised or treatment-as-usual control group, and use of self-reported outcome measures. Many of the participants and those in the control group were also engaged in other prison drug treatment services, e.g.

methadone maintenance, which may indicate that they already had a higher degree of motivation than other prisoners who were not engaged with the services.

The authors considered the high level of retention and completion rates in the programme very positive. There was a statistically significant reduction in the ambivalence of the participants around their drug use after the intervention. The authors concluded that group-based motivational interventions could be useful in a prison setting but they require further investigation.

3. Sources and methodology

3.1 Sources

Notable sources include the Annual Reports of the Irish Prison Service, reports of the Inspector of Prisons and responses to Parliamentary Questions. Also, publications and the website of the Irish Penal Reform Trust are of use.

3.2 Methodology

Galander, T and Rosalim, J and Betts-Symonds, G and Scully, M. (2014) A survey of patients on methadone programmes in Wheatfield Prison, Dublin, Ireland. Heroin Addiction and Related Clinical Problems, 16 (2). pp. 17-22. This research study surveyed all prisoner patients in Wheatfield Prison (Dublin) on wha programmes on 3 October 2011. Socio-demographic and medical data were recorded. Basic descriptive statistics were used. 119 out of 664 prisoners were on methadone treatment.

Community Return Evaluation

The study cohort comprised all 761 Community Return Programme participants between October 2011 and December 31st 2013. A mixed methods approach was used in the study, as well as analysis of anonymised pre-existing data on participants held by the Irish Prison Service. Questionnaires were completed by relevant Irish Prison Service and Probation Service personnel.

Motivational intervention for problem substance users in prison. Prisoners in Mountjoy prison who were current substance users were invited to participate in the intervention programme. Demographic data, sentencing details, drug use history, risk behaviour and current engagement with treatment services were collected for each participant using a semi-structured interview. The primary outcome measure of treatment effectiveness was collected using the internationally validated questionnaire – Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). This measures a participant's readiness for change. It was filled out by the participant (self-reported) before and after the treatment.

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European Monitoring Centre for Drugs and Drug Addiction

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.

There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

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